



Add a New Participant

1. Search for participant to verify they are not already in WISPr

NOTE: Search by current and previously used names; also search with **just** the date of birth or SSN

- Click: Participant / Family Search



- Enter: Information for the participant, then click: Search

Example, if you are looking for Parry Testing you might enter the following:

Search for...
☒ All ☐ Family ☐ Participant

Last Name: First Name: Date of Birth: SSN: Phone: Card #:

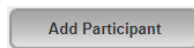
No Matches Found.

- If participant is not in WISPr, “No Matches Found.” will be shown
2. Repeat: process to search for the Responsible Adult (if necessary, create a new family)
 3. Click: on line with responsible adult’s name

FID	PID	First	MI	Last	CAT	DOB
F652		Beth	B	Testing-Wic		5/12/1989

Pages: 1 - 1 (1 items) **[1]**

4. Click: Add Participant



5. Enter: all required (*) information and optional information if appropriate

- Idaho Medicaid # and/or Cross Reference (optional)

Idaho Medicaid #: (optional) Cross Reference #: (optional)

- Date of Birth and Gender (required)

Date of Birth:* Gender:* ☐ Male ☐ Female

- Name (first and last are required)

First Name:* MI: Last Name:* Suffix: SSN:

☐ Has Preferred Name

- Social Security Number and Preferred Name (optional)

- Responsible Adult and Years of education (required for females over 9 years old)

Is this person the Responsible Adult for this family?
☐ Yes ☐ No ☐ Has Preferred Name

Years of education:

- Foster Child and Mother (required)

Foster Child: ☐ Yes ☒ No Mother:*

- Ethnicity, Race, and Language (required)

- If interpreter needed (non-English speaking) select the Interpreter box

Ethnicity: ☐ Hispanic ☐ Non-Hispanic
 Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander
 Language:
 Interpreter? ☐

- Initial Contact Date, Application Date, Proof of Identity, and Physically present (required)

Initial Contact Date:*
 Application Date:*
 Proof of Identity:*
 Physically present?*:

- All women participants: Category (required)

- If Pregnant: EDD Date and Proof of Pregnancy (required)

✓ All other information if applicable

Category:*
 EDD Date:*
 Multi-Fetal Gestation: ☐
 Proof of Pregnancy:
☐ Pregnant & Breastfeeding Infant < 12 months old
☐ Pregnant & Breastfeeding Multiples < 12 months old
 BF Infant DOB:

6. Click: Save

SAVE



IDAHO DEPARTMENT OF
HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH



This publication was made possible by Grant 207IDID7W1003 from the United States Department of Agriculture. Its contents are solely the responsibility of the Idaho WIC program and do not necessarily represent the official views of the USDA.

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